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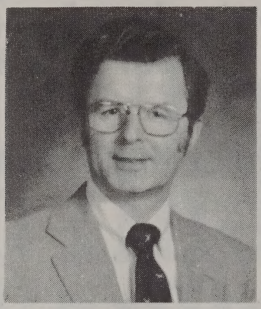

PRESIDENT'S PAGE

PHILIP B. STODDARD, M.D.
President

Happy New Year to all from the Hampden District Medical Society. May you be blessed with good health and a sturdy resolve. The Society will strive to serve your needs and keep you well informed.

1981-1982 may be the year of the Hippocrat inserts, but it seems to be the most practical way to keep you informed. I believe my primary role as your President is to do just that. In keeping with that resolve, I invite you to read the enclosed insert which is a copy of a letter sent from Mr. John Larkin Thompson, of Blue Shield to Stanley Wyman, M.D., President, MMS and Bartley Cilento, M.D. This letter was sent in reply to stated objections of MMS to the Blue Cross/Blue Shield merger bill, Senate 866. Mr. Thompson's letter was circulated to all members of the MMS Council, courtesy of Louis Alifano, M.D. Chairman of the Board of Blue Shield. Please read the letter and compare it to Dr. Wyman's list of complaints as each item is discussed. I would be most interested in your comments. □

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MILITARY MEDICINE CONCEPTS

Mission: To provide the medical supports needed to maintain the highest possible degree of combat readiness and effectiveness.

a. Mission all inclusive, tactical medical support, medical support, medical and dental care, flight and missle medicine, environmental health service.

*b. Medical Service includes: Active Force, Medical Units of the Air National Guard and USAF Reserve.

In most references, the Air Guard and United States Air Force Reserve are called the Reserve of the Air Force.

Individual units may have specific missions, but collectively the mission is the same.

Training Goals:

It has been said by experts and strategists that any future conflict will be a "come as you are" type of action. The luxury of; mobilizing and training over periods of weeks and months as in the past will not be possible. Therefore, all training, active and reserve forces alike, is designed for readiness and rapid mobility.

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The echelon concept, an adaptation of classical wartime casualty treatment principles, allows for four levels of patient care: from the first level where first aid is provided by oneself or a buddy to the fourth level where comprehensive, sub-specialty care is available.

All this reaction requires training and planning so that when a soldier yells "I'm hit" on the battlefield, a series of sequential events occurs like a highly orchestrated symphony to provide the best possible care to our military.

There are many medical readiness training programs conducted throughout the year that provide realistic battlefield training so that participants can experience the combat environment while learning the complexities of casualty management. Also, in-house programs at the unit level such as disaster scenarios and chemical defense training that keep the personnel trained.

Why Do These Individuals Do It?

This question is often asked to 104 Clinic personnel. No one in the 104th is under military obligation to be in the unit. All personnel are volunteers. What makes a nurse drive from Long Island one week-end a month to give immunizations? What makes a successful eye surgeon give up an entire week-end to do physicals and consultations? What makes a radiology resident willing to drive from Boston?

The answer will vary from person to person. It may be because it's something different to do, for the retirement and pay benefits, patriotism, etc.

Whatever the answer, one thing is common. These people must sacrifice time from family, friends, recreation, etc. to train for a job that hopefully we won't ever be called upon to do. But if our way of life is threatened, then there will be a strong viable and ready resource to meet that challenge.

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Any physician interested in seeing what the 104th is all about or that might have a desire to join, please feel free to call. We would be glad to invite you out to a week-end to see all of us in operation. Simply call 1-568-8711 and ask for SMSgt. Jean Denoncourt.

Background Information or Terms

Training - 4 UTA's per month
15 days - annual training per year

UTA - Unit Training Assembly
4-hour period - 4 UTA's = 2 days = 16 hours

Annual training - 15 days spent with the unit in a deployment with the Group at an active duty military hospital or in a short-term training course.

Former Members of Clinic: Members of Hampden District Medical Society

Dr. Joseph Bagamary
Dr. George Reynolds

- Westfield - of Family Medicine Association

Dr. Geoffrey McCarthy - Westfield
While not a member of the clinic, is a current member of the 104 TAC Fighter Group as a **Fighter Pilot.**

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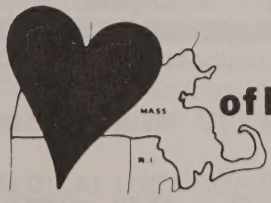
In The Hart  **of New England**

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Mission Of The 104 Tactical Clinic

The mission of the 104 Tactical Clinic is to provide limited diagnostic and therapeutic service in the field of general medicine and surgery, under field or combat conditions. Provide outpatient service, such as medical administration, routine physical examinations, immunizations, and other related functions. Provide Enviromental Health, Veterinary, and dental services, within its capabilities. Provide Aviation Medicine service which conducts aircrew effectiveness programs, flying safety programs and other medical activities relative to flying.

Our major workload consists of physical examinations and immunizations.

Physical examinations, are essentially those for:

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Annually for females, and industrial type workers
Annually for aircrews
Periodic examinations according to age
Separation, due to medical reasons

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The Present Clinic

The 104th Tactical Clinical is under the command of Lt Col Ronald C. Szarlan, with a total staff of 1 physician, 1 dentist, 1 optometrist, 3 nurses, and 24 medical personnel. Ninety percent of the medical staff are in medically orientated civilian life positions as can be seen in Table 2. Civilian fields of interest range from opthamology, to general dentistry, to prosthodontics, to nursing staff development coordnator, to operating room nurse, to tumor registry registrar, to visiting nurse, to OSHA administration, to emergency room nurse, kidney dialysis technician, and physician assistants. Clinic personnel represent a total of over 300 years of military service with backgrounds ranging from Marine to Army training. Four of our enlisted personnel are Registered Nurses while one is also a Nurse Practitioner and another is a physician's assistant and one is a Licensed Practical Nurse in civilian life. Three of our medical technicians are Registered Emergency Medical Technicians (EMT's), while one is an Industrial Health technician in civilian life. Three civilian Licensed Practical Nurses also serve in our clinic.

The 104th Tactical Clinic was the first clinic to recruit an active Nun, with Sister Judith Rosenthal, a member of the congregation of Sisters of St. Joseph joining in 1971. A Licensed Practical Nurse for 10 years, TSgt Rosenthal has most recently appeared on Cable Television in conjuntion with the parish to talk about her work with the Air National Guard.

Dr. Szarlan has taken a Forensic Dental Program at the Armed Force Institute of Pathology, Washington D.C. He has made his services available to the local medical examiner.

Two officers are enrolled in correspondence courses and all airmen are working on advanced levels.

To compliment the past commanders winning of the Flight Surgeon of the Year Award in 1979, two of our clinic members have been added to the Outstanding Air National Guard recipients. SMSgt Jean Denoncourt was awarded the Outstanding Medical Technician of the Year Plague in 1978, and Lt. Col Ronald Szarlan, our present commander, was awarded the Outstanding Medical Officer of the Year Plague in 1978. □

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I HISTORY

The 104th Tactical Clinic was federally recognized in April 1956, as the 104th United States Air Force Dispensary. The original mission of the Dispensary was to support our Air Defense Group. Commanded originally by Capt Stephen P. Ferraro with the strength of 10 officers and 32 airmen, the 104th Tactical Dispensary supported the 104th Tactical Fighter Group which was equipped with F-94 type aircraft. The command of the 104th Tactical Clinic changed from Capt James D Allan to Col Philip B Burke to Capt James D Anderson until 1970, Lt Col Richard B Yule until 1979. In November 1979 Lt. Col Ronald C. Szarlan took command.

The Dispensary was subsequently changed to a Clinic in April 1973 and up until July 1979 had a manning document authorizing 10 officers and 19 airmen.

The increase in activity of the 104th Tactical Clinic over the past several years is well exemplified by physicals and ancillary tests performed. Since January 1972, the total number of physicals increased from 194 to over 650 average per year. During this interval, training for the members of the Clinic was accelerated while at the same time, participation in community activities increased as well. Particulary note worthy of mention, is that despite the absence of an assigned Flight Surgeon, the Clinic has supported the conversion process to a new aircraft, an extensive ORI, Red Flag, 4 mini deployments, a Prime Beef deployment and a bare base type deployment to Wendover Utah. At no time was the Group mission impaired or compromised. This is primarily due to the spirit, dedication and extra hours of effort by all clinic personnel. This is certainly in keeping with the "can do" spirit of the Air National Guard. One point any individual can notice is that the quality, expertise and performance of the unit is constantly seeking new levels of aspirations.

The 104th Tactical Clinic has so far been honored by receiving three Outstanding Air National Guard Awards.

Because of the long and seasoned Service experience, with the clinic presently having no obligees as members, a seasoned and

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varied approach to Clinic operation and training is possible.

II. SPECIFIC CONTRIBUTIONS TO FURTHERENCE OF MEDICAL PROGRAMS

1. Breast Self Exam Program

2. Advanced First Aid

3. CPR Training

4. GMT Training

5. Flight Medicine

6. Clinic Renovations

7. Publications

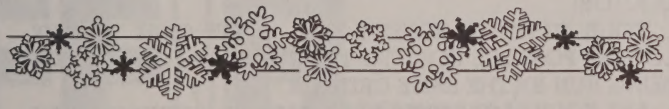
8. MSLO Program

9. AMSUS Participation

10. Participation by Clinic Members Which Enhance the Image of Group, Air National Guard, and USAF.

11. Training to Other Sections

12. Dental Clinic - Prevention Dental Program



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III. SPECIFIC CONTRIBUTIONS TO UNIT MISSION

1. Clinic support of unit deployments 1 Oct80-30 Sep 81
   a. Red Flag, Nellis AFB 13 Nov-14 Dec 80
   b. CE Deployment, Savannah/Eglin AFB 24 Jan-7 Feb 81
   c. Wendover Utah (bare base deployment) 16-30 May 81
   d. Quick Thrust, Savannah 24-28 Aug 81

2. 4 Thunderwart Exercises (Base wide Disaster and Chemical Warfare)
3. Physical Statistics
4. Visiting Flight Surgeon Program
5. Base wide classes in CPR and Anti Choking procedures
6. Support of Base Open House Programs

IV. PROFESSIONALISM DISPLAYED BY CLINIC MEMBERS

1. Meeting Attendance In the past all officers of the clinic have attended the AMSUS conference. This has resulted in increased visibility of the clinic members as well as increased knowledge of the Guard and Air Force mission in general. The professionals are willing to take time out from their private practices in order to attend these meetings is evidence of the high motivation on the part of the clinic members. At these meetings papers have been presented by the members of the clinic.

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2. Association Membership. All profesional members of the clinic are members of AMSUS and the Alliance for Air National Guard Flight Surgeons.

3. National Membership. Lt. Col Szarlan is Historian for the Alliance of Air National Guard Flight Surgeons and Vice President of the Academy of Air National Guard Dentists. Major Montague is Secretary/ Treasurer of the Air National Guard Optometric Society. Lt. Col Montgomery is Secretary for the Association of Air National Guard Nurses. Capt Hayes is a member of the Nominating Committee of Association of Air National Guard Nurses.

The extra time and effort these individuals put forward to assist the National Guard programs is exemplified with frequent contact with the Air Surgeon, National Guard Bureau with regards to problems at the Pentagon Level.

4. Faculty Associations. Professional members of the clinic have a multitude of faculty associations which include Harvard Medical School, Harvard Dental School, The Massachusetts College of Optometry. These associations reflect positively on the entire clinic and the Guard, and the United States Air Force.

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V. AWARDS AND HONORS PRESENTED TO UNIT AND PERSONNEL

1. Air Force Outstanding Unit Award - All clinic members for support of the 104th Tactical Fighter Group.
2. SMSgt Denoncourt - Air Force Commendation Medal, Air National Guard Meritorious Service Award, several letters of Commendation, Red Cross certificate of Appreciation.
3. Capt Duffany - Air Force Commendation Medal.
4. TSgt Mello - Meritorious Service Award (for saving a life), 7 letters of Commendation.
5. SSgt Gale - Letters of Commendation for Red Flag, Nellis AFB and Wendover Utah.
6. TSgt Elloian - Letter of Commendation - Please AFB, N.H.
7. MSgt Loiselle - Letter of Commendation - CE Deployment 1980, 1981.
8. TSgt Sanderson - Letter of Commendation - Wendover Utah.
9. Lt. Col Szarlan - Certificate of Appreciation from Alliance of ANG Flight Surgeons; Senate Citation; Letter of Commenation from Maj Gen Guice; Fellowship Nomination to the Academy of Dentistry International; House of Representatives Citation; Letter of Commendation -Seymour Johnson AFB Dental Clinic; Candidate for Fellow status in the International College of Dentists.
10. SSgt Tremble - Clinic Airman of the Year 1979; Group Airman of the Year 1979.
11. SSgt Walsh - Clinic Airman of the Year 1980; Group Airman of the Year 1980.
12. TSgt Hall - Clinic Airman of the Year 1976.
13. TSgt Wilkerson - Clinic Airman of the Year 1976.
14. TSgt Mello - Clinic Airman of the Year 1975.
15. SrA Dupont - National Dean's List; Alpha Nu Omega Honor Society.
16. TSgt Rosenthal - Meritorious Service Ribbon with Cluster; Participant in film showing dual roles of citizen and soldier.

Highlights Of The Executive Committee

Committee met on December 15, 1981.

Dr.Fitzpatrick, Chairman of Committee on Education & the Library was present to give a report.

The minutes of the November meeting were accepted. The appointments made by Dr. Stoddard to serve on the Physician Ethics Committee were approved by the committee. Correspondence between the MMS, the HDMS and local Pediatricians relating to the Medicaid problem was discussed. A meeting with William Munier, M.D., E.V.P. of the MMS and the Pediatricians will be held in the near future.

Additional Bylaw changes were discussed by the committee and approved. A letter from Dr. Willcutts, Chairman of the Educational committee of the Committee on Education and the Library was read as informational. Programs are being planned.

The name of Dr. J.J. Siragusa has been presented to the Nominating Committee of the MMS to run for the position of Vice President. Final nominations will be made in February.

Dr. Hough discussed the recent Interim meeting of the AMA held in Las Vegas. The Handbook was passed among the committee for their perusal of the mountains of work accomplished at the meeting.

Dr. Remsberg presented the proposed budget for 1982-1983. The Committee approved this budget which will be given to the Membership at the January 26, 1982 District Meeting.

The meeting was adjourned at 9:30 P.M.

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The present communication network which is utilized in Springfield is a patchwork system that fails to provide adequate backup, range, versatility, and/or accessibility. The City of Springfield has established an Emergency Medical Services donations account to receive and dispense funds to purchase communications equipment for a new system. Both the donations account and communications system will be overseen by the recently created Emergency Medical services Commission comprising representatives from Baystate Medical Center, Mercy Hospital, the Springfield Fire and Police Commissions, and a Mayoral appointee. The Commission is charged with responsibility for designing and implementing a comprehensive emergency medical system (EMS) for the City of Springfield.

The intended communication network would consist of ambulance-to-hospital and hospital-to-hospital radio links coordinated and controlled by an emergency medical communication center. The center would have the capability to communicate directly with public safety agencies (police and fire departments, civil defense, etc.) by radio and/or telephone, and would be linked by a VHF system with the outlying ambulance services and hospitals.

In effect, Springfield's system would form the nucleus for the future development of a comprehensive emergency medical communication for the entire Pioneer Valley. The system is also designed to provide for telemetry systems, which will ensure treatment for cardiac and severe trauma patients as paramedics and advanced life support technologists are trained.

Our investigation into the costs of a state of the art emergency medical communication system requires a capital investment of $200,000. To date, the Emergency Medical Services Communiation Fund Drive Committee has raised $120,000. We need your help to bring us to our goal. Please send your contribution, which is tax deductible, to: Emergency Medical Communication Fund Donations Account, c/o EMS Commission, City Hall-Room 226, Springfield, MA 01103

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AMA Meeting - Interim 1981 December 6 - 9, 1981

I am happy to report to all AMA members that your organization is alive and well. Thanks to increased membership, a high rate of return on investment, and tight financial controls, fiscal '81 is showing an unexpectedly good "bottom line." Non-dues income is now 49% and investments are being shifted to long-term, reflecting a financial stability not present in 1974. Much of this can be attributed to Dr. James Sammons, our Executive Vice-President, who is a no-nonsense administrator. With approval of the Trustees and the House of Delegates, he has orchestrated a continuing reorganization of AMA functions. Some programs have been dropped, others redirected, and some new functions added. The resulting package is more cost-effective and more responsive to physicians' needs. Personally, I find AMA staff better informed and more helpful as this reorganization proceeds. Although increased costs have necessitated a 1982 dues increase, and although non-members continue to enjoy many services paid for by AMA members, we are getting more for our dues dollars than ever before.

As usual, the House of Delegates considered a huge number of problems affecting physicians. These ranged from the increasing costs of medical education and confidentiality of medical information to goalie

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face masks and automobile seat restraints. The time spent on discussions was not always equivalent to the significance of the decision, but such is the way with democratic organizations. Massachusetts delegates were particularly active in strengthening AMA policy on handgun control, equal rights for women, attempting (unsuccessfully) to increase the role of medical students and residents in the AMA, and gaining approval of new Continuing Medical Education guidelines. Dr. James McDonough of Winchester served as chairman of one of the nine reference committees, a position of considerable responsibility.

Many reports and resolutions dealt with the interlocking problems of health manpower and allied health personnel. Although the GMENAC model continues to be suspect, particularly in specialty areas, a physician surplus appears to be inevitable. Approval was voted for the AMA to allow market forces to regulate physician supply but to "help physicians adjust to changing circumstances." At the same time, it was noted that allied health personnel, particularly nurses, have important responsibilities to fulfill and reasonable expectations for professional advancement. As health delivery systems become modified by health care costs, we will need wise national leadership to integrate our interests and our actions, and to prevent oppressive federal regulations.

The major function of the AMA has always been in scientific education. Again this year, this was demonstrated by the quality and variety of the reports of the Council of Scientific Affairs. Six were accepted at this meeting, providing succinct, current reviews of available knowledge on:

A. "Agent Orange"
B. Genetic Counseling and Prevention of Birth Defects
C. Health Care Needs of Homosexuals
D. Prescription of Tranquilizers for Women
F. DMSO
G. Estrogen Replacement in the Menopause

One report, on periodic medical examination, was returned to the Council for further study. They will probably be published in JAMA, but I can provide copies now to those who are interested.

The primary need of the AMA at the moment is communication. I am impressed that communication between the House of Delegates and the Board of Trustees (that the House elects) is excellent. Several resolutions from the House were passed only to find that the mechanism for implementation was in place all ready to go, or that the Board had been carrying out the action for some time. But I fear that communication between AMA members and the delegates (that the members elect) is not as good. In 4 years, only one member has asked me to act for him at an AMA meeting. It took two tries, but his wish was accomplished at this meeting. You are reading this report, but will you discuss it with your friends? Once again, I repeat that John Ayres and I are anxious and willing to represent your views at AMA meetings, if we know what they are. □

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VITALLY YOURS

With an increase in health planning capacity Springfield's Planning Department, an ever improving emphasis is being and will be made in collecting and reporting health data pertaining to the city. Collection and analysis of data for the calendar year of 1980 through the cooperative efforts of the City Clerk's Office as well as the Planning and Health Departments have yielded some very interesting information and may be of help to various parties in Springfield Interested in planning and developing needed programs.

VITAL STATISTICS FOR 1979 AND 1980

SPRINGFIELD

	1980	1979
Population	152,3191	153,4782
Total deaths occuring in the City	2,527	2,373
Non-resident deaths occuring in the City	1,041	1,057
Resident deaths occurring in the City (except stillborns)	1,486	1,316
Resident deaths occurring elsewhere in the State	194	240
Resident Death Rate (per 1000 population)	11.0	10.1

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Total live births occurring in the City	5,280	4,707
Non-resident live births occurring in the City	2,954	2,492
Resident live births occurring in the City	2,326	2,157
Resident live births occurring elsewhere in the state	79	87
Total resident live births	2,405	2,244
Resident Birth Rate (per 1000 live births)	15.8	14.6
Marriages in Springfield	1,436	942
Marriage Rate (per 1000 population)	9.4	6.1
Premature births reported to Health Department	76	94

1. 1980 Census.
2. Estimated, based on interpolation between 1970 and 1980 census. It is different than what appeared in the 1979 Annual Report and, therefore, the rates have been changed.

GENERAL MORTALITY

Two sets of mortality data are presented: official mortality data for 1979 from the division of Health Statistics in the Massachusetts Department of Public Health and an unofficial court of deaths for 1980 as processed by the Springfield Health Department. State data, although one year behind, is presented because deaths of Springfield residents who died outside of the city (15-20% of all deaths) are included, the causes of death coded by the State agency are uniform so that comparisons can be made between Springfield and the State as well as other cities, and the State's use of computers allows for a more sophisticated analysis. On the other hand, the 1980 coding by the City's Health Department is current and indicative of trends even though not official.

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OFFICIAL MORTALITY DATA

Analysis of the official 1979 mortality data yields the following:

1. Up to age 70, heart disease causes more than twice as many deaths to males than females.
2. Cancer is the leading cause of death for females under age 70, approximately 40% of all female deaths from age 30-70.
3. For males, age 30-70, heart disease holds a similar position as the number one cause of death.
4. Stroke (cerebro-vascular disease) as a major killer does not emerge until age 70 and over, and more so for women than for men.
5. Similarly, influenza and pneumonia are not major factors in mortality until age 70 and over.
6. Under the age of 70, 62% of all deaths are to males, while only 38% are to females.
7. Between the ages of 10 and 40, males are three times more likely to die than are females.
8. Of deaths from accidents, most of those under 40 are caused by motor vehicles, while most of those over 70 are caused by falls.
9. Cirrhosis of the liver is most prevalent as a cause of death in the 40-60 age range.
10. Nearly half of all deaths under the age of 40 (excluding infant deaths) are caused by accidents.

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UNOFFICIAL MORTALITY DATA

It must be remembered that the data below do not include 194 (11.5%) of Springfield residents who died outside of the city and the deaths were coded by the Springfield Health Department, whose system may differ from the States' official agency; hence, this data should be considered as indicators.

Mortality by 12 Major Causes, by Sex,
Springfield Residents Who Died in Springfield, 1980

CAUSE	Total N	Total %	Male N	Male %	Female N	Female %
1. Heart Disease	527	35.5	282	35.8	245	35.1
2. Cancer	330	22.2	187	23.7	143	20.4
3. Stroke	177	11.9	72	9.1	105	15.0
4. Accidents (all)	57	3.8	29	3.7	28	4.0
5. Arterlosclerousis	48	3.2	27	3.4	21	3.0
6. Bronchitis, Emphysema,Asthma	45	3.0	30	3.8	15	2.1
7. Diabetes	39	2.6	22	2.8	17	2.4
8. Cirrhosis of Liver	34	2.3	20	2.5	14	2.0
9. Flu & Pneumonia	32	2.2	16	2.0	16	2.3
10. Infant Prematurity	29	2.0	20	2.5	9	1.3
11. Homicide	9	.6	4	.5	5	.7
12. Suicide	9	.6	6	.8	3	.4
All Others	150	10.1	73	9.3	77	11.0
TOTAL	1486	100.	788	100.0	698	100.0

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COMPARATIVE MORTALITY DATA (1969-1978)

The Massachusetts Department of Public Health during the first part of 1981 released data for the ten year period 1969-78 which compares the mortality experience of each city and town with that of the state. For 24 different causes of death plus for all causes, the data show whether the local experience (observed deaths) is greater or less than what would be expected if the rates for the state (adjusted for age and sex) were applied locally.

The terms greater or less than expected are quantified by their statistical significance. For instance, the term "greater than expected" means that there is less than a 5 in 100 chance that the difference in the two figures (observed vs. expected deaths) is due to random error. The term "much greater than expected" means that there is less than a 1 in 100 chance that the difference is due to random error. Likewise for "less and "much less than expected."

A caveat to take into consideration when viewing the data is that the Mass. DPH used the U.S. census for 1969-1973 population base and its own population estimates in 1975 for the 1974-1978 data. Its population estimate for Springfield in 1975 was an increase of 5,000 over 1970, whereas the 1980 census shows an overall decrease of 11,000 over the past decade. Thus, it is likely that the population estimate for 1974-1978 was too high. This would have the effect of making the mortality data appear conservative. That is, with a smaller population base, the "expected" number of deaths would decrease, thus pushing specific causes of death to the "greater than" end of the spectrum.

Another caveat to consider is that while the comparison between Springfield and the state is adjusted for age and sex, the urban-rural difference is not accounted for. Thus, a difference between Springfield and the State may be due to the attendant differences in socio-economic and racial characteristics between an urban area like Springfield and the state as a whole.

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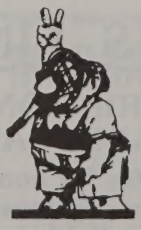

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SPRINGFIELD MORTALITY RATES COMPARED TO THE STATE

1969-1973

Much Greater Than Expected	Greater Than Expected	Less Than Expected	Much Less Than Expected
Total, all causes (M. F. T)	All Cancers (T)	Hyper-tension (T)	Hyper-tension (T)
Cancer of Pancreas (M, T)	Leukemia (T)		
Diabetes (M, T)	Bronchitis, Emphysema, & Asthma (F)		
Stroke (M, F, T)			
Bronchitis, Emphysema & Asthma (M, T)			
Cirrhosis of Liver (M, F, T)			
All Accidents (M, F, T)			

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SPRINGFIELD MORTALITY RATES COMPARED TO THE STATE

1974-1978

Much Greater Than Expected	Greater Than Expected	Less Than Expected	Much Less Than Expected
Cancer of Cervix, Uteri(F,T)	Bladder Cancer (T)	Pneumonia (M)	Heart Disease (F, T)
Diabetes (F,T)	Cirrhosis of Liver (M,T)	Motor Vehicle Accidents(M)	Artery, Arteriole & Capillary(F)
Stroke (M,F,T)			Pneumonia (T)
All Accidents (F,T)			Motor Vehicle Accidents(T)

M-Male
F-Female
T-Total

Data were computed for the following causes of death by sex: Total, All causes; All cancers; cancer of-stomach, large intestine and rectum, liver, pancreas, bronchus and lung, breast, cervix uteri, other female organs, prostate, bladder, kidney; leukemia; diabetes; hypertension; ischemic heart disease; cerebrovascular disease (stroke); disease of arteries, arterioles and capillaries; pneumonia; bronchitis, emphysema, and asthma; cirrhosis of the liver; all accients; motor vehicle accidents; suicides.

Any of those causes of death not appearing in the table above had a comparative rate (neither less nor greater) with the state as a whole.

COMPARATIVE MORTALITY ANALYSIS

1. Overall, the death rate in Springfield in comparison with that of the state was lower in the 1974-1978 period than in the 1969-1973 period. However, this decrease may be an artifact of the high population estimates for the 1974-1978 period.
2. On the whole, more diseases had a "less than" or "much less than" rating in 1974-1978 than in 1969-1973. Again, however, this favorable trend may be largely due to an inaccurate population estimate.
3. On the other hand, mortality rates for stroke, diabetes, and all accidents (especially for females) were consistently higher than expected over both five year periods.

JOHN C. AYRES, M.D.

IN MEMORIAM

KHALID M. RANDHAWA, M.D.

Khalid M. Randhawa, M.D. died on December 12, 1981 as a result of an automobile accident.

Dr. Randhawa practiced Otorhinolaryngology in Westfield.

Born in Pakistan, he graduated from Liaquat Medical College in Pakistan. He interned at Catholic Medical Center New York City and he had his residency in Otorhinolarynogology at the University of Vermont in Burlington.

Dr. Randhawa was certified by the American Board of Otorhinolaryngology in November of 1974.

Sympathy is extended to his family in Pakistan and his friends. □

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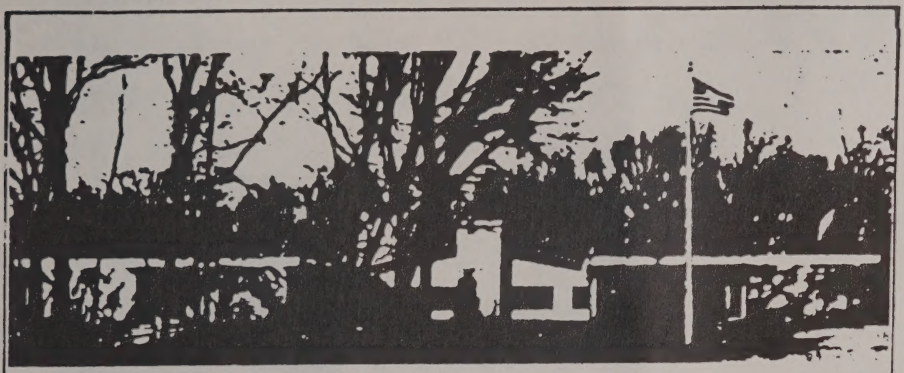

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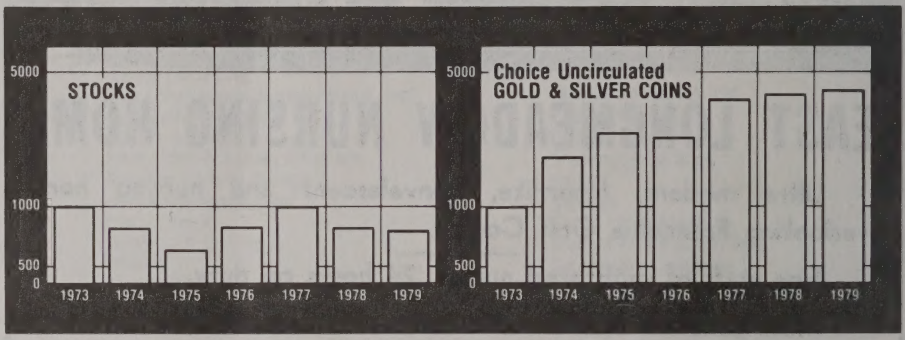

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